Appendix 17
Completion Instructions For the HCFA 1500 Claim Form For Clozapine Management Services

Use these claim form instructions to complete claims for clozapine management services. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Note: Medicaid providers should *always* verify recipient eligibility before rendering services.

Element 1 — Program Block/Claim Sort Indicator
Enter claim sort indicator "P" in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a — Insured's I.D. Number
Enter the recipient's 10-digit Medicaid identification (ID) number exactly how it appears on the current Medicaid identification card.

Element 2 — Patient's Name
Enter the recipient's last name, first name, and middle initial from the Medicaid ID card. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female with an "X."

Element 4 — Insured's Name (optional)

Element 5 — Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (optional)

Element 7 — Insured's Address (optional)

Element 8 — Patient Status (optional)

Element 9 — Other Insured's Name
Do not enter anything in this element if no health insurance is indicated under "Other Coverage" on the recipient's ID card.

If the recipient's Medicaid ID card indicates private health insurance under "Other Coverage," you must attempt to bill the private health insurance. If you receive payment from the private insurer, indicate the following code in the first box of Element 9.

<u>Code</u>	<u>Description</u>
OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The claim indicates the amount paid by the health insurance company to the provider or the insured.

Leave this element blank if the other insurer denies payment.

Element 10 — Is Patient's Condition Related to (optional)

Element 11 — Insured's Policy, Group or FECA Number
Leave this element blank.

Elements 12 and 13 — Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 — Date of Current Illness, Injury, or Pregnancy (optional)

Element 15 — If Patient Has Had Same or Similar Illness (optional)

Element 16 — Dates Patient Unable to Work in Current Occupation (optional)

Element 17 — Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a — I.D. Number of Referring Physician
Enter the referring or prescribing provider's eight-digit Medicaid provider number. If the referring provider is not Medicaid-certified, enter the provider's license number.

Element 18 — Hospitalization Dates Related to Current Services (optional)

Element 19 — Reserved for Local Use (optional)

Element 20 — Outside Lab
If laboratory services are billed, check either "yes" or "no" to indicate whether an outside lab was used.

Element 21 — Diagnosis or Nature of Illness or Injury
The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (optional)

Element 23 — Prior Authorization (optional)

Element 24a — Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

• When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
• When billing for two, three, or four dates of service on the same line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g. DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if all of the following apply:

• All dates of service are in the same calendar month.
• All services are billed using the same procedure code and modifier, if applicable.
• All procedures have the same type of service (TOS) code.
• All procedures have the same place of service (POS) code.
• All procedures were performed by the same provider.
• The same diagnosis is applicable for each procedure.
• The charge for each procedure is identical. (Enter the total charge *per detail line* in Element 24f.)
• The number of services performed on each DOS is identical.
• All procedures have the same HealthCheck indicator.
• All procedures have the same emergency indicator.

Element 24b — Place of Service
Enter the appropriate single-digit place of service code for each service.

Numeric	Description
0	Other
2	Outpatient Hospital
3	Office
4	Home

Element 24c — Type of Service Code
Enter TOS "1" here.

Element 24d — Procedures, Services, or Supplies
Enter the appropriate five-character procedure code.

Element 24e — Diagnosis Code
Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis in Element 21.

Element 24f — Charges
Enter the total charge for each line.

Element 24g — Days or Units
Enter a quantity of one for each calendar week (Sunday through Saturday) of clozapine management for recipients who have weekly white blood counts. Enter a quantity of one for each two-week period (Sunday through Saturday) of clozapine management for recipients who have biweekly white blood counts.

Element 24h — EPSDT/Family Planning
Enter "H" for each procedure that was performed as a result of HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i — EMG (optional)

Element 24j — COB (optional)

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Element 24k — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider *for each procedure* This is different from the billing provider number used in Element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of Element 24k directly above Element 30. Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 — Federal Tax ID Number (optional)

Element 26 — Patient's Account No.

Optional— The provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status (R/S) Report.

Element 27 — Accept Assignment

(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in Element 29, "OI-P" must be indicated in Element 9.)

Element 30 — Balance Due

Enter the balance due as determined by subtracting the recipient spenddown amount in Element 24k and the amount paid by health insurance in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider of the authorized representative must sign Element 31. Also enter the month, day, and year the form is signed in MM/DD/YY or MM/DD/YYYY format.

Note: This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Rendered

If the services were provided to a recipient in a nursing facility (POS "7" or "8"), indicate the nursing facility's eight-digit provider number.

Element 33 — Physician's Suppliers Billing Name, Address, ZIP Code, and Telephone #

Enter the Wisconsin Medicaid billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of Element 33, enter the billing provider's eight-digit provider number.

Appendix